STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATI	E SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:	(12) Mezin zz ek	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	ľ í	PLETED
MINDIEMIN	or condition	155430	A. BUILDING		- 03/21/	
		195430	B. WING			2011
NAME OF I	PROVIDER OR SUPPLIEF	R		ADDRESS, CITY, STATE, ZIP CC	DDE	
			I	18TH ST		
HICKOR'	Y CREEK AT ROCH	HESTER	ROCH	ESTER, IN46975		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORE	RECTION	(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AF	IOULD BE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)		DATE
K0000	A Life Safety Code Recertification and		K0000	Attached for your review	w and	
Koooo	_	Survey was conducted by	Koooo	anticipated approval yo		
		•		the completed Plan of (
		Department of Health in		for the annual Life Safe		
	accordance with	42 CFR 483.70(a).		Survey conducted on M		
				2011 at Hickory Creek		
	Survey Date: 03	3/21/11		Rochester, Rochester, Please be advised that		
				intent to have this plan		
	Facility Number	: 000326		correction also serve as		
	Provider Numbe	er: 155430		Allegation of Compliand	ce.	
	AIM Number: 1	.00290770		Compliance is effective		
				20, 2011. Should you h		
	Surveyor Philli	p Komsiski, Life Safety		questions regarding the Plan of Correction/Alleg		
	Code Specialist	p Romsiski, Elic Surety		Compliance, please do		
	Code Specialist			hesitate to contact	1101	
	A 4 41. in T i Co Ci o Co	4. Callan and History		me.Sincerely,Laura		
		ty Code survey, Hickory		AlbrightAdministrator		
		ter was found not in				
	•	Requirements for				
	•	Medicare/Medicaid, 42				
	CFR Subpart 48:	3.70(a), Life Safety from				
	Fire and the 200	0 edition of the National				
	Fire Protection A	Association (NFPA) 101,				
	Life Safety Code	e, (LSC), Chapter 19,				
	_	Care Occupancies and				
	410 IAC 16.2.	,				
	110 1110 10.2.					
	This one story fo	acility was determined to				
		(22) construction and was				
		-				
	, i	The facility has a fire				
		th smoke detection in the				
	_	s open to the corridors and				
		detectors in resident				
	sleeping rooms.	The facility has a				
	capacity of 36 ar	nd had a census of 31 at				

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

Y4QW21

Facility ID:

000326

If continuation sheet

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		155430	A. BUILDING B. WING		03/21/2011		
NAME OF P	PROVIDER OR SUPPLIER		STREET A	ADDRESS, CITY, STATE, ZIP CODE			
HICKOR'	Y CREEK AT ROCH	IESTER	340 E 18TH ST ROCHESTER, IN46975				
(X4) ID		TATEMENT OF DEFICIENCIES	ID PROVIDER'S PLAN OF CORRECTION		(X5)		
PREFIX TAG	*	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE COMPLETION DATE		
	the time of this survey.						
	The facility was	found not in compliance ntioned regulatory					
			1	<u> </u>	ļ.		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING			COMPLETED	
		155430	B. WING 03/21		03/21/20	011	
NAME OF I	DROLUDED OD GLIDDLIED		<u> </u>	STREET	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER			340 E 1	18TH ST		
	Y CREEK AT ROCH		_		ESTER, IN46975		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	(EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIAT	TΕ	COMPLETION DATE
		· · · · · · · · · · · · · · · · · · ·	17.00		What corrective action will be do	ına İ	
K0038		ation and interview, the	K00	138	by the facility?	one_	04/20/2011
SS=F		ensure the means of			<u>by the facility :</u>		
		of 3 exits were readily			It is the intent of this facility to ha	ave	
		sidents without a clinical			exit access arranged so that exits		
		ng specialized security			readily accessible at all times. No		
		19.2.2.2.4 requires doors			residents were adversely affected	by	
	•	means of egress shall			this practice. All residents have accessibility to exit facility witho	,,,t a	
	not be equipped	with a latch or lock that			clinical diagnosis requiring	ut a	
	requires the use of	of a tool or key from the			specialized security measures. A		
	egress side. Exc	eption No. 1 requires			sign will be posted at each exit		
	door locking arra	ingements without			access that states "Code is month	and	
	_	nall be permitted in health			year example for April code would		
		, or portions of health			be 0411*" The code will be change	ged	
	-	, where the clinical needs			each month by the maintenance director.		
	-	equire specialized			director.		
	security measure	• •			How will the facility identify other	er_	
	-	ff can readily unlock such			residents having the potential to b	<u>se</u>	
	•	s. This deficient practice			affected by the same practice, and		
		5 % of residents as well			what corrective action will be tak	en?	
	as visitors.	70 of residents as well			No masidanta vyana advantaly offac	ata d	
	as visitois.				No residents were adversely affect by this practice. An in-service w		
	Pludius 1 1 1				provided to all staff on March 29		
	Findings include	•			2011 regarding exit access and ne		
					door code procedures.		
		ations on 03/21/11 during					
		11:45 a.m. and 1:00 p.m.			What measures will be put into p		
		ance Supervisor, all exit			to ensure that this practice does n	ot_	
	_	netically locked and could			occur?		
		ering a four digit code,			Exit access will be monitored by	the	
	but the code was	not posted.			Maintenance Director or designed		
	Additionally, the	re was a sign posted			ensure codes are properly change	d	
	above the keypac	d stating the code was			according to posted sign on a		
	available at the n	urses' station. Based on			monthly basis. Any issues or		
	interview with th	e Administrator			concerns will be corrected immediately.		
					miniculatory.		
					•		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155430		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 03/21/2011	
	PROVIDER OR SUPPLIER		STREET. 340 E ^	ADDRESS, CITY, STATE, ZIP CODE 18TH ST ESTER, IN46975	1
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
	acknowledged appercent of the reclinical diagnosis building. A residuagnosis requirimeasures would	the observations, it was opproximately forty five sidents do not have a sit to be in a secure dent without the clinical ng specialized security have to ask a staff em out if they did not		How will the corrective action be monitored to ensure the deficier practice does not recur and what will be put into place? The Maintenance Director or designee will report to the QA committee monthly any issues a concerns regarding exit access a follow up required.	nd

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING			COMPLETED	
		155430	B. WING 03/21/2			03/21/2	011
			b. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER			l	8TH ST		
HICKOR'	Y CREEK AT ROCH	IESTER	ROCHESTER, IN46975				
(X4) ID		TATEMENT OF DEFICIENCIES	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE			(X5)	
PREFIX	*	CY MUST BE PERCEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	17.00	TAG	,		DATE
K0050		review and interview, the	K00	150	What corrective action will be done by the facility?		04/20/2011
SS=C	facility failed to	conduct fire drills at			<u>- oy me memry .</u>		
	unexpected times	s in 3 of 4 third shift fire			It is the policy of this facility to h		
	drills for 2010.	This deficient practice			fire drills at unexpected times und		
	affects all resider	nts in the facility as well			varying conditions, at least quarte on each shift. A schedule has bee	-	
	as staff and visito	ors.			created that only the Administrate		
					and Maintenance Director are aw		
	Findings include				of to schedule out fire drills for th		
	Based on review	of Fire Drill records on			year at unexpected times and und		
	03/21/11 at 2:59	p.m. with the			varying conditions (attachment A).	
	Maintenance Sup	pervisor, three of four			How will the facility identify other	er	
	third shift fire dri	ills were conducted			residents having the potential to b		
	hetween 5:15 a n	n. and 5:45 a.m. Based			affected by the same practice and	_	
		03/21/11 at 3:01 p.m.			what corrective action will be tak	en?	
		-			No residents were adversely affect	otad	
		ance Supervisor, it was			by this practice.	ieu	
	_	e fire drills done for the			by this practice.		
	third shift of 201	0 were not held			What measures will be put into pl		
	randomly.				to ensure that this practice does n	<u>ot</u>	
	3.1-19(b)				occur?		
	3.1-51(c)				- All staff was in-serviced on Marc	h l	
	J.1 J1(U)				29, 2011 regarding fire drill		
					procedures. The Maintenance		
					Director was in-serviced on April	8,	
					2011 regarding fire drill procedur	es	
					and holding them at unexpected		
					times under varying conditions, a	t	
					least quarterly on each shift. If further issues occur further educa	tion	
					or discipline will occur.	uon	
					or albeighine will beeut.		
					How will the corrective action be	_	
					monitored to ensure the deficient		
					practice does not recur and what	QA_	
					will be put into place?		

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155430			A. BUILDING B. WING (X3) DATE SURVEY COMPLETED 03/21/2011			LETED
	PROVIDER OR SUPPLIER Y CREEK AT ROCH		STREET ADDRESS, CITY, STATE, ZIP CODE 340 E 18TH ST ROCHESTER, IN46975			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AP DEFICIENCY)	ECTION OULD BE PROPRIATE	(X5) COMPLETION DATE
	· ·			The Maintenance Director designee will monitor all to on a monthly basis and brissues or concerns to QA of for follow up.	r or fire drills ing any	l .

000326

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING			COMPLETED	
		155430	B. WIN			03/21/2011	
					ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER			340 E 1	8TH ST		
	Y CREEK AT ROCH			ROCHE	ESTER, IN46975		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATI DEFICIENCY)		ΓE	COMPLETION	
TAG		·	7700	TAG	,		DATE
K0062		ation and interview, the	K00	62	What corrective action will be do by the facility?	<u>ne</u>	04/20/2011
SS=E	_	replace 1 of 1 sprinkler			by the facility:		
		ninistrator's office which			It is the policy of this facility to h	ave	
	_	glass tube. NFPA 25,			automatic sprinkler systems that a		
		.1.1 requires any			continuously maintained in reliab		
	sprinkler shall be	replaced which is			operating condition and are inspe	cted	
	painted, corroded	l, damaged, loaded, or in			and tested periodically. The		
	the improper orie	entation. This deficient			sprinkler head located in the Administrator's office was replac	ad	
		fect the 5 residents			with a new sprinkler head.	cu	
	•	ining/lounge area next to			with a new sprinkler nead.		
		's office as well as staff			How will the facility identify other	er_	
	and visitors.		residents having the potential to		<u>se</u>		
	wild visitors.				affected by the same deficient		
	Findings include	-			practice and what corrective action	<u>on</u>	
	i manigs merade	•			will be taken?		
	Based on observa	ation on 03/21/11 at			No residents were adversely affect	eted	
	11:25 a.m., one a	utomatic sprinkler in the			by this practice. The Maintenanc	е	
		ffice had paint on the			Director or designee will check		
		d on interview on			sprinkler heads monthly to ensure they are continuously maintained		
	03/21/11 at 11:28				reliable operating condition and a		
		pervisor it was confirmed			issues or concerns will be fixed	,	
	the sprinkler head				immediately.		
	-	ffice had paint on the					
	glass tube.	mee nau pami on me			What measures will be put into pl		
	giass tube.				to ensure that this practice does n	<u>ot</u>	
	2.1.10(1-)				occur?		
	3.1-19(b)				The Maintenance Director was		
					in-serviced on April 8, 2011		
					regarding proper procedures on		
					continuously maintaining sprinkle		
					heads. The Maintenance Director	r or	
					designee will check all sprinkler		
					heads monthly for 6 months to en all sprinkler heads are maintained		
					properly with no debris or paint o		
					1 -F - J - III - II - II - II - II - II -		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155430			(X2) MULTIPLE CO A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/21/2011			
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 340 E 18TH ST ROCHESTER, IN46975				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ON (X5) D BE COMPLETION DATE		
				them. Issues and concerns we fixed immediately.			
				How will the corrective actio monitored to ensure the defic practice does not recur and w will be put into place?	<u>ient</u>		
				The Maintenance Director or designee will check all sprink heads monthly for six months ensure all sprinkler heads are maintained properly. Mainte Director or designee will brin issues or concerns to the mon committee for follow up.	cler s to nance ng any		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED
		155430	B. WIN			03/21/2011
NAME OF I	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE	
HICKUD,	Y CREEK AT ROCH	IECTED		1	18TH ST ESTER, IN46975	
				ID	1	1 (75)
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL	PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	DATE
K0130	Based on observa	ation and interview, the	K01	30	What corrective action will be do	<u>ne</u> 04/20/2011
SS=E	facility failed to	ensure the location of 1			by the facility?	
	of 1 liquefied pet	troleum gas (LPG)			It is the intent of this facility to the	
	containers was at	t least 25 feet away from			storage of flammable liquids or g to be in accordance with NFPA 55	
	a designated smo	oking area. LSC			and that the distance measured in	
	8.4.3.1(3) require	es the storage and			direction from the point of discha	rge
	handling of flam	mable liquids or gases to			of a container is 25 feet from a designated smoking area. The	
	be in accordance	with NFPA 58, 1998			designated smoking area was mo	I
	Edition Liquefied	d Petroleum Gas Code.			to an area to meet this standard of March 21, 2011.	n
	NFPA 58, Section	n 3-2.2.2 requires			March 21, 2011.	
	containers install	ed outside of buildings to			How will the facility identify other	
	be in accordance	with Table 3-2.2.2. and			residents having the potential to be affected by the same practice and	
	Section 3-2.2.2(d	l) requires the distance			what corrective action will be don	- 1
	measured in any	direction from the point			- TDI 1 : 1 : 1:	
	of discharge of a	container pressure relief			The designated smoking area was moved on March 21, 2011 to an a	
	valve, the vent of	f a fixed maximum liquid			that is more than 25 feet from	
	level gauge on a	container, or the installed			flammable liquids or gases. No residents were adversely affected	hv
	location of the fil	lling connection of a			this practice. All staff was	oy
	container to any	exterior source of			in-serviced on the location of the	
	ignition, opening	s into direct-vent (sealed			designated smoking area and that smoking will only be allowed in the	I
	combustion syste	em) appliances, or			designated area on March 29, 201	I
	mechanical venti	lation air intakes shall be			What many 211 have the state of	
	in accordance wi	th Table 3-2.2.2(d).			What measures will be put into plus to ensure that this practice does n	
	` '	indicates the minimum			occur?	_
	distance between	a LPG container with a			- The Maintenance Director or	
	water capacity of	f 501-2000 gallons and an			designee will monitor the designa	ited
	exterior ignition	source is 25 feet. This			smoking area on a consistent basi	
	deficient practice	e could affect 10 residents			ensure visitors, staff, and resident adhere to smoking in designated	SS
	located next to th	ne smoking area as well			areas only. Any issues or concern	ns

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155430		A. BUILDING	UNSTRUCTION	COMPLETED 03/21/2011	
		100400	B. WING	ADDRESS STEEL STEEL STEEL STEEL STEEL	03/21/2011
	PROVIDER OR SUPPLIER		340 E	ADDRESS, CITY, STATE, ZIP CODE 18TH ST ESTER, IN46975	
				1	(VE)
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	as staff or visitor	s using the smoking area		will be rectified immediately.	
		ne facility near the		II. III.	
	generator.	·		How will the corrective action b monitored to ensure the deficien	
	Findings include	:		practice does not recur and what will be put into place?	
	Based on observa 12:45 p.m. with the Supervisor, the Lapacity of sever gallons was 18 feats smoking area. B 03/21/11 at 12:50 Supervisor acknown measurement, the	ation on 03/21/11 at the Maintenance LPG container with a n hundred and fifty eet from the designated ased on interview on 0 p.m. the Maintenance owledged after making a te location of the smoking ance from the LPG		The Maintenance Director or designee will report to the QA committee month any issues or concerns the designated smoking area or visitors, staff, or residents smoking within feet of flammable liquids gases.	nly with

000326

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155430			A. BUILDING COMPLE			(X3) DATE SURVEY COMPLETED 03/21/2011
NAME OF PROVIDED HICKORY CREE (X4) ID	EK AT ROCH		B. WIN	340 E 1	ADDRESS, CITY, STATE, ZIP CODE 18TH ST ESTER, IN46975 PROVIDER'S PLAN OF CORRECTION	(X5)
`		CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	DATE
K0147 SS=D facility include multiply substity Article permit not be of a s would well a Findir Based 12:06 Super reside a pow bed a Based p.m. i Maint aware plugg	d on observaty failed to eding powers plug adapter itute for fixed le 400-8 requitted, flexible e used as a structure. The daffect 2 reas visitors and many included on observation of pm. with the rvisor, a nebent in room a verstrip at the and not direct don intervied on intervied it was acknown and the control of the property of the	ention and interview, the ensure extension cords trips and nonfused as a ed wiring. NFPA 70, uires unless specifically e cords and cables shall substitute for fixed wiring his deficient practice sidents in the room as and staff.	K01		What corrective action will be do by the facility? It is the intent of this facility to ensure extension cords including power strips and non-fused multipadapters are not used as a substitution fixed wiring and that all medicequipment is plugged directly into wall outlet and not a power strip. The medical device was unplugged from the power strip and plugged directly into the wall outlet on Ma 21, 2011. All other rooms were toured to ensure no medical device were plugged into power strips. How will the facility identify other residents having the potential to be affected by this practice and what corrective action will be done? All staff was in-serviced on Marc 29, 2011 regarding not plugging medical devices into power strips. The Maintenance Director or designee will monitor resident root to ensure medical devices are not plugged into power strips on a monthly basis. If a medical device found to be plugged into a power strip staff will be disciplined appropriately. No residents were affected by this practice. What measures will be put into plut on ensure that this practice does not recur. The Maintenance Director or	olug tite cal o a ed arch ees b h

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: Y4QW21 Facility ID:

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155430		(X2) MULTIPLE CO A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/21/2011		
HICKOR	PROVIDER OR SUPPLIER Y CREEK AT ROCH		340 E 1	ADDRESS, CITY, STATE, ZIP CODE 18TH ST ESTER, IN46975	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
				designee will monitor resident ro to ensure medical devices are no plugged into power strips on a monthly basis. This will be adde the monthly maintenance rounds sheet for room checks. How will the corrective action be monitored to ensure the deficien practice does not recur and what will be put into place? This will be added to the monthl maintenance rounds sheet for roo checks and any issues or concern will be reported to the QA comm monthly for follow up.	ed to s e t QA y om ns